

(2) *Common ownership.* Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

(3) *Control.* Control exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(c) *Application.* (1) Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

(2) If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the provider, in effect the items are obtained from itself. An example would be a corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider may not exceed the market price.

(d) *Exception.* (1) An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the fiscal intermediary (or, if the provider has not nominated a fiscal intermediary, CMS), that—

(i) The supplying organization is a bona fide separate organization;

(ii) A substantial part of its business activity of the type carried on with the provider is transacted with others than the provider and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of serv-

ices, facilities, or supplies furnished by the organization;

(iii) The services, facilities, or supplies are those that commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions; and

(iv) The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

(2) In such cases, the charge by the supplier to the provider for such services, facilities, or supplies is allowable as cost.

Subpart B—Accounting Records and Reports

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

(b) *Frequency of cost reports.* Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis.

(c) *Recordkeeping requirements for new providers.* A newly participating provider of services (as defined in § 400.202

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of this chapter) must make available to its selected intermediary for examination its fiscal and other records for the purpose of determining such provider's ongoing recordkeeping capability and inform the intermediary of the date its initial Medicare cost reporting period ends. This examination is intended to assure that—

(1) The provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes under section 1815 of the Act; and

(2) No financial arrangements exist that will thwart the commitment of the Medicare program to reimburse providers the reasonable cost of services furnished beneficiaries. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement including, but not limited to, that described in paragraph (d) of this section and in § 413.24.

(d) *Continuing provider recordkeeping requirements.* (1) The provider must furnish such information to the intermediary as may be necessary to—

(i) Assure proper payment by the program, including the extent to which there is any common ownership or control (as described in § 413.17(b)(2) and (3)) between providers or other organizations, and as may be needed to identify the parties responsible for submitting program cost reports;

(ii) Receive program payments; and

(iii) Satisfy program overpayment determinations.

(2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records include, but are not limited to, matters pertaining to—

(i) Provider ownership, organization, and operation;

(ii) Fiscal, medical, and other recordkeeping systems;

(iii) Federal income tax status;

(iv) Asset acquisition, lease, sale, or other action;

(v) Franchise or management arrangements;

(vi) Patient service charge schedules;

(vii) Costs of operation;

(viii) Amounts of income received by source and purpose; and

(ix) Flow of funds and working capital.

(3) The provider, upon request, must furnish the intermediary copies of patient service charge schedules and changes thereto as they are put into effect. The intermediary will evaluate such charge schedules to determine the extent to which they may be used for determining program payment.

(e) *Suspension of program payments to a provider.* If an intermediary determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such provider will be suspended until the intermediary is assured that adequate records are maintained. Before suspending payments to a provider, the intermediary will, in accordance with the provisions in § 405.372(a) of this chapter, send written notice to such provider of its intent to suspend payments. The notice will explain the basis for the intermediary's determination with respect to the provider's records and will identify the provider's recordkeeping deficiencies. The provider must be given the opportunity, in accordance with § 405.372(b) of this chapter, to submit a statement (including any pertinent evidence) as to why the suspension must not be put into effect.

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§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

However, if governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.